Maryland Health Quality & Cost Council Disparities Workgroup

Final Report

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Disparities Workgroup Charge

- **The Workgroup shall develop <u>recommendations</u> for best practices, monitoring, and financial incentives for the <u>reduction of disparities</u> in the health care system.**

- **<u>These disparities may include</u>:**
  - **Workforce**

  - **Quality of care within an office or hospital setting**

  - **Access to care within a health plan or health care system**

  - **Understanding of care within a health care setting**

  - **Others as determined by the Committee**

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Targeted Outcomes and Supporting Data

- **For 14 <u>ambulatory care</u> measures used by AHRQ, all but one showed meaningfully worse Black rates than White rates.**

  - **Admission rates were as much as 4.5 times higher for Blacks for some conditions.**

  - **The percent of excess Black admissions due to disparity was as high as 78% for some conditions.**

- **The <u>highest</u> Black death rate was 1,211 deaths per 100,000 while the <u>lowest</u> Black death rate was 661 deaths per 100,000.**

- **The <u>highest</u> White death rate was 988 deaths per 100,000 while the <u>lowest</u> White death rate was 560 deaths per 100,000.**

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Targeted Health Disparities

Asthma

Heart Disease

Diabetes

Maryland Prevention Quality Indicators by Race and Ethnicity with Black % excess
http://statesnapshots.ahrq.gov/snaps10/SnapsController?menuId=47&state=MD&action=disparities&level=80

Ambulatory Care Measures	Whites (Non-Hisp)	Blacks (Non-Hisp)	B/W Ratio	Rank	B-W Differ	Rank	Black % excess method 1	Black % excess method 2
Respiratory Disease								
Admissions for chronic obstructive pulmonary disease per 100,000 population, age 18 and over	190.8	179.19	0.94	14	-11.61	14	N/A	N/A
Bacterial pneumonia admissions per 100,000 population, age 18 and over	260.11	355.93	1.37	10	95.82	7	26.9%	26.9%
Pediatric asthma admissions per 100,000 population, ages 2-17	95.98	294.09	3.06	3	198.11	3	67.4%	67.4%
Asthma admissions per 100,000 population, age 18 and over	115.34	312.68	2.71	6	197.34	4	63.1%	63.1%
Asthma admissions per 100,000 population, age 65 and over	262.86	519.71	1.98	9	256.85	2	49.4%	49.4%
Immunization-preventable influenza admissions per 100,000 population, age 65 and over	23.51	24.33	1.03	13	0.82	13	3.4%	3.4%
Heart Disease								
Admissions for hypertension per 100,000 population, age 18 and over	44.39	200.66	4.52	2	156.27	6	77.9%	77.9%
Admissions for congestive heart failure per 100,000 population, age 18 and over	351.43	896.83	2.55	7	545.40	1	60.8%	60.8%
Admissions for angina without procedure per 100,000 population, age 18 and over	47.82	65.07	1.36	11	17.25	11	26.5%	26.5%
Diabetes								
Admissions for diabetes with short-term complications per 100,000 population, ages 6-17	20.56	22.25	1.08	12	1.69	12	7.6%	7.6%
Admissions for diabetes with short-term complications per 100,000 population, age 18 and over	46.09	134.31	2.91	4	88.22	8	65.7%	65.7%
Admissions for diabetes with long-term complications per 100,000 population, age 18 and over	101.61	291.09	2.86	5	189.48	5	65.1%	65.1%
Admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over	10.09	46.72	4.63	1	36.63	10	78.4%	78.4%
Lower extremity amputations among patients with diabetes per 100,000 population, age 18 and over	27.44	64.46	2.35	8	37.02	9	57.4%	57.4%

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Health Intervention Targets

- **<u>Poor health outcomes</u> in general and <u>poor minority health outcomes</u> in particular, result in part from the following <u>modifiable factors</u>:**

  - **Health Care Factors**

  - **Community Factors**

  - **Individual Factors**

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Proposed Interventions

1. Create Health Enterprise Zones (HEZ)

2. Create the "Maryland Health Innovation Prize"

3. Expand the scope of Maryland's current reimbursement incentives for quality, and make them <u>race and ethnicity-specific</u>

Definition of the Health Enterprise Zone (HEZ)

- **A Health Enterprise Zone (HEZ) is a <u>geographic area</u> in Maryland that is eligible for <u>specific policy incentives</u> and <u>funding opportunities</u> for both new and existing providers.**

- **HEZs will have <u>poor health outcomes</u> and/or <u>documented health disparities</u>**

- **<u>All-group, Group-specific, and Racial/Ethnic Minority</u> metrics in the Zone exceed the Statewide metrics**

- **Increased minority hospital admission and/or emergency department visit rates for <u>Asthma</u>, <u>Diabetes</u>, <u>Hypertension</u>, and other <u>Ambulatory Care Sensitive Conditions</u> (ACSC)**

Expected Benefits of the HEZ

- Increased <u>supply and diversity</u> of the local health care workforce, especially in primary care

- Increased use of <u>community health workers</u>

- Improved <u>community leadership</u> development

- <u>Reduced</u> racial and ethnic <u>minority health disparities</u> and <u>improved</u> minority health <u>outcomes</u>

- Reductions in <u>preventable hospital admission</u> and/or <u>emergency department visit</u> rates for Asthma, Diabetes, Hypertension, and other ACSCs

Statute-based Incentives of the HEZ

- **Statute-based incentives utilize policy-based financial incentives that are available to all eligible parties within HEZs.**

  - **<u>Tax incentives</u> (property and/or income and hiring credits)**

  - **<u>Free or low rent use</u> of city/county space for some term to <u>set up or expand</u> a practice**

  - **<u>Funding and assistance</u> with <u>health information technology</u> implementation**

  - **<u>Loan assistance repayment programs</u> for qualifying service in the HEZ**

  - **<u>Funding and assistance</u> with conversion to a <u>Patient Centered Medical Home</u> (PCMH)**

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Contract-based Incentives of the HEZ

- **Contract-based interventions utilize a contract for services model to allocate funding to an HEZ that applies and is approved for funding.**

  - Training and Deploying <u>Community Health Workers</u>

  - Providing financial assistance to providers for <u>language interpretation services</u>

  - Providing Cultural, Interpretation, and Health Literacy <u>training to health care providers</u>

  - Developing and supporting a <u>Community Coalition</u> and providing <u>leadership training</u>

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HEZ Assessment Benchmarks

- **Number of persons <u>newly enrolled in health insurance</u>**

- **Number of persons <u>receiving particular health services </u>(e.g. screening, treatment)**

- **Number <u>new providers</u> added to the HEZ**

- **Provider <u>workforce diversity</u> in the HEZ**

- **ACSC <u>hospitalization and emergency department visit rates</u> in the HEZ**

- **Healthcare Effectiveness Data and Information Set (HEDIS) measures**

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Maryland Health Innovation Prize (I-Prize)

- A **financial reward** and **public recognition** for an individual, group, organization, or coalition to acknowledge **innovative health interventions**.

- **Model innovations** can develop from **outside the health care system** that could have increased potential for resolving persistent health care delivery challenges.

- These prizes will be awarded for proven interventions that address both **wide-ranging health disparities** as well as those which may be **unique to a particular community**.

Expected Benefits of the I-Prize

- **Innovations in community health and public health**

- **Innovations from the <u>non-health sector</u>**

- **Innovations from <u>youth and young adults</u>**

- **Improved <u>health status</u> in local minority communities**

- **<u>Societal sectors</u> outside of health care delivery could bring resources, value added, and partners whose collaboration <u>addresses causal factors</u> outside the health system.**

- **<u>Reduced</u> racial and ethnic <u>minority health disparities</u> and <u>improved</u> minority health <u>outcomes</u>**

Implementation of the I-Prize

- **An <u>Accountable Organization</u> needs to be identified or established to administer the Prize. This organization would be responsible for:**

  - **Engaging industries, businesses, and health delivery systems to participate in <u>building "The Purse"</u>**

  - **Defining the <u>eligibility criteria</u> for the Prize**

  - **Defining the <u>criteria for ranking and selection</u> among applicants**

  - **<u>Reviewing materials</u> submitted in support of nominees**

  - **Determining the periodic <u>winner</u> of the Prize**

  - **<u>Disbursing funds</u> to the Prize winners**

CURRENT Tracking of Performance Incentive Data

- **Health care <u>performance data</u> are or will be <u>analyzed and incentive payments made</u> (or potentially penalties assessed) to hospitals or providers <u>based on the results</u>.**

  - <u>Hospital Care Incentives</u> *(Health Services Cost Review Commission)*
    - **Quality Based Reimbursement**
    - **Maryland Hospital Acquired Conditions (MHAC)**
    - **Maryland Hospital Preventable Readmissions (MHPR)**
    - **Admission-Readmission Revenue (ARR) Hospital Payment Constraint Program**

  - <u>Primary Care Incentives</u> *(Maryland Health Care Commission)*
    - **Shared Savings Incentive in the Patient Centered Medical Home Program**

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PROPOSED Racial & Ethnic Tracking of Performance Incentive Data

- Implementation of racial/ethnic performance data tracking will require **legislation directing the HSCRC and the MHCC** to **include racial and ethnic data** as part of their data collection.

- As an alternative, the **MHCC and HSCRC** could establish a **process and timeline** to:

  - **Study the feasibility** of including racial/ethnic performance data tracking in quality incentive programs

  - **Report data** by race and ethnicity where feasible to the General Assembly by the 2013 session

  - **Explain the limitations** where data cannot be reported by race and ethnicity and describe necessary changes to overcome those limitations.

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Expected Benefits of Racial & Ethnic Performance Data Tracking

- **Improvement in minority <u>health care quality</u>**

- **<u>Reduced</u> racial and ethnic <u>minority health disparities</u> and <u>improved</u> minority health <u>outcomes</u>**

- **Reductions in <u>preventable hospital admission</u> and/or <u>emergency department visit rates</u> for Asthma, Diabetes, Hypertension, and other ACSCs**

- **<u>Health care cost savings</u> to private and public payers**

Next Steps

- **Health Quality and Cost Council reviews and endorses the Disparities Workgroup Report**

- **Approved report is submitted to the Governor as part of the Health Quality and Cost Council Annual Report**

- **Implementation of strategies via legislation or study**

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